CONFERENCE COMMITTEE REPORT

MADAM PRESIDENT and MR. SPEAKER: Your committee on conference on Senate amendments to **HB 2064** submits the following report:

The House accedes to all Senate amendments to the bill, and your committee on conference further agrees to amend the bill as printed with Senate Committee amendments, as follows:

On page 4, following line 3, by inserting:

"Sec. 4. K.S.A. 2014 Supp. 40-2,118 is hereby amended to read as follows: 40-2,118. (a) For purposes of this act a "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

(b) An insurer that has knowledge or a good faith belief that a fraudulent insurance act is being or has been committed shall provide to the commissioner, on a form prescribed by the commissioner, any and all information and such additional information relating to such fraudulent insurance act as the commissioner may require.

(c) Any other person that has knowledge or a good faith belief that a fraudulent

insurance act is being or has been committed may provide to the commissioner, on a form prescribed by the commissioner, any and all information and such additional information relating to such fraudulent insurance act as the commissioner may request.

(d) (1) Each insurer shall have antifraud initiatives reasonably calculated to detect fraudulent insurance acts. Antifraud initiatives may include~~:~~ fraud investigators, who may be insurer employees or independent contractors~~; or~~ and an antifraud plan submitted to the commissioner no later than July 1, 2007. Each insurer that submits an antifraud plan shall notify the commissioner of any material change in the information contained in the antifraud plan within 30 days after such change occurs. Such insurer shall submit to the commissioner in writing the amended antifraud plan.

The requirement for submitting any antifraud plan, or any amendment thereof, to the commissioner shall expire on the date specified in ~~paragraph (2) of this~~ subsection (d)(2) unless the legislature reviews and reenacts the provisions of ~~paragraph~~ subsection (d)(2) pursuant to K.S.A. 45-229, and amendments thereto.

(2) Any antifraud plan, or any amendment thereof, submitted to the commissioner for informational purposes only shall be confidential and not be a public record and shall not be subject to discovery or subpoena in a civil action unless following an in camera review, the court determines that the antifraud plan is relevant and otherwise admissible under the rules of evidence set forth in article 4 of chapter 60 of the Kansas Statutes Annotated, and amendments thereto. The provisions of this paragraph shall expire on July 1, 2016, unless the legislature reviews and reenacts this provision pursuant to K.S.A. 45-229, and amendments thereto, prior to July 1, 2016.

(e) Except as otherwise specifically provided in ~~subsection (a) of~~ K.S.A. 2014 Supp. 21-5812(a), and amendments thereto, and K.S.A. 44-5,125, and amendments thereto, a fraudulent insurance act shall constitute a severity level 6, nonperson felony if the amount involved is $25,000 or more; a severity level 7, nonperson felony if the amount is at least $5,000 but less than $25,000; a severity level 8, nonperson felony if the amount is at least $1,000 but less than $5,000; and a class C nonperson misdemeanor if the amount is less than $1,000. Any combination of fraudulent acts as defined in subsection (a) which occur in a period of six consecutive months which involves $25,000 or more shall have a presumptive sentence of imprisonment regardless of its location on the sentencing grid block.

(f) In addition to any other penalty, a person who violates this statute shall be ordered to make restitution to the insurer or any other person or entity for any financial loss sustained as a result of such violation. An insurer shall not be required to provide coverage or pay any claim involving a fraudulent insurance act.

(g) This act shall apply to all insurance applications, ratings, claims and other benefits made pursuant to any insurance policy.

Sec. 5. K.S.A. 2014 Supp. 40-22a13 is hereby amended to read as follows: 40-22a13. On and after July 1, 2011, for the purposes of K.S.A. 40-22a13 through 40-22a16, and amendments thereto:

(a) "Adverse decision" means a utilization review determination by a third-party administrator, a health insurance plan, an insurer or a health care provider acting on behalf of an insured that a proposed or delivered health care service which would otherwise be covered under an insured's contract is not or was not medically necessary or the health care treatment has been

determined to be experimental or investigational and:

(1) If the requested service is provided in a manner that leaves the insured with a financial obligation to the provider or providers of such services; or

(2) the adverse decision is the reason for the insured not receiving the requested services.

(b) "Emergency medical condition" means:

(1) The sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part or would place a person's health in serious jeopardy;

(2) a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the insured or would jeopardize the insured's ability to regain maximum function; or

(3) a medical condition for which coverage has been denied based on a determination that the recommended or requested health care service or treatment is experimental or investigational, if the insured's treating physician certifies, in writing, that the recommended or requested health care service or treatment for the medical condition would be significantly less effective if not promptly initiated.

(c) "External review organization" means an entity that conducts independent external reviews of adverse decisions pursuant to a contract with the commissioner. Such entity shall ~~have experience serving as the external quality review organization in health programs administered by the state of Kansas, or~~ be a nationally accredited external review organization which utilizes

health care providers actively engaged in the practice of their profession in the state of Kansas who are qualified and credentialed with respect to the health care service review. In the event the entity has no Kansas providers available who are qualified and credentialed with respect to the review of any case, the external review organization shall have the discretion to employ health care providers who actively engage in such health care provider's practice outside the state of Kansas.

(d) "Health insurance plan" means any hospital or medical expense policy, health, hospital or medical service corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans.

(e) "Insured" means the beneficiary of any health insurance company, fraternal benefit society, health maintenance organization, nonprofit hospital and medical service corporation, municipal group-funded pool, and the self-funded coverage established by the state of Kansas, or any hospital or medical expense, health, hospital or medical service corporation contract or a plan provided by a municipal group-funded pool.

(f) "Insurer" means any health insurance company, fraternal benefit society, health maintenance organization, nonprofit hospital and medical service corporation, provider sponsored organizations, municipal group-funded pool and the self-funded coverage established by the state of Kansas for its employees.

Sec. 6. K.S.A. 40-2203 is hereby amended to read as follows: 40-2203. (A) Required provisions. Except as provided in paragraph (C) of this section every such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this

subsection in the words in which the same appear in this section, but the insurer, at its option, may substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner of insurance which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subsection or at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner of insurance may approve.

(1) A provision as follows: "*Entire contract; changes:* This policy, including the endorsement and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions."

(2) A provision as follows: "*Time limit on certain defenses:* (a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatement, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period."

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two year period, nor to limit the application of subsections (B) (1), (2), (3), (4) and (5) in the event of misstatement with respect to age or occupation or other insurance.

A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50, or (2) in the case of a policy issued after age

44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption *"Incontestable":* "After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(b) "No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss has existed prior to the effective date of coverage of this policy."

(3) A provision as follows: "*Grace period:* A grace period of _____" (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) "days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force." A policy which contains a cancellation provision may add, at the end of the above provision, "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof." A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision, "Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to the last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted."

(4) A provision as follows: "*Reinstatement:* If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or

by any agent duly authorized by the insurer to accept such premium without requiring in connection therewith an application for reinstatement shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement." The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue.

(5) A provision as follows: "*Notice of claim:* Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____" (insert the location of such office as the insurer may designate for the purpose), "or to any authorized agent of the insurer, with

information sufficient to identify the insured, shall be deemed notice to the insurer." In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provisions: "Subject to the qualification set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.

(6) A provision as follows: "*Claim forms:* The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made."

(7) A provision as follows: "*Proofs of loss:* Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of

such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required."

(8) A provision as follows: "*Time of payment of claims:* Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid _____" (insert period for payment which must not be less frequently than monthly) "and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof."

(9) A provision as follows: "*Payment of claims:* Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death, at the option of the insurer, may be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured." The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer: "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $_____" (insert an amount which shall not exceed $1,000), "to any relative by blood or

connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment. Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person."

(10) A provision as follows: "*Physical examinations and autopsy:* The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law."

(11) A provision as follows: "*Legal actions:* No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of five years after the time written proof of loss is required to be furnished."

(12) A provision as follows: "*Change of beneficiary:* Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy."

The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

(13) A provision as follows: "*Cancellation by insured:* The insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt of such notice or on such later date as may be specified in such notice. In the event of cancellation or death of the insured, the insurer will promptly return the unearned portion of any premium paid. The earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation." When approved by the commissioner, the "cancellation" provision appearing in subsection (B)(8) may be substituted for the above.

(B) *Other provisions:* Except as provided in paragraph (C) of this section, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section, but the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner of insurance which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner of insurance may approve.

(1) A provision as follows: "*Change of occupation:* If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous

than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation."

(2) A provision as follows: "*Misstatement of age:* If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age."

(3) A provision as follows: "*Other insurance in this insurer:* If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for _____" (insert type of coverage or coverages) "in excess of _____" (insert maximum limit of indemnity or

indemnities) "the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate"; or, in lieu thereof: "Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies."

(4) A provision as follows: "*Insurance with other insurers:* If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the 'like amount' of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage." If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase "_____ expense incurred benefits." The insurer, at its option, may include in this provision a definition of "other valid coverage," approved as to form by the commissioner of insurance, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of

this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner of insurance. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage." The provisions of this paragraph shall not apply to any individual policy of accident and sickness insurance, as defined in K.S.A. 40-2201, and amendments thereto.

(5) A provision as follows: "*Insurance with other insurers:* If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined." If the foregoing policy provision is included in a policy which also contains the next preceding policy provision there

shall be added to the caption of the foregoing provision the phrase "_____ other benefits." The insurer, at its option, may include in this provision a definition of "other valid coverage," approved as to form by the commissioner of insurance, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the commissioner of insurance. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third-party liability coverage shall be included as "other valid coverage." The provisions of this paragraph shall not apply to any individual policy of accident and sickness insurance, as defined in K.S.A. 40-2201, and amendments thereto.

(6) A provision as follows: "*Relation of earnings to insurance:* If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or the average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this

policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time." The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50, or (2) in the case of a policy issued after age 44, for at least five years from its date of issue. The insurer, at its option, may include in this provision a definition of "valid loss of time coverage," approved as to form by the commissioner of insurance, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner of insurance or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.

(7) A provision as follows: "*Unpaid premium:* Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be

deducted therefrom."

(8) A provision as follows: "*Cancellation:* The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation."

(9) A provision as follows: "*Conformity with state statutes:* Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes."

(10) A provision as follows: "*Illegal occupation:* The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation."

(11) A provision as follows: "*Intoxicants and narcotics:* The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician."

(C) *Inapplicable or inconsistent provisions:* If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the commissioner of insurance, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(D) *Order of certain policy provisions:* The provisions which are the subject of subsection (A) and (B) of this section, or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy, shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

(E) *Third-party ownership:* The word "insured," as used in this act, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

(F) *Requirements of other jurisdictions:* (1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this act and which is prescribed or required by the law of the state under which the insurer is organized.

(2) Any policy of a domestic insurer, when issued for delivery in any other state or

country, may contain any provision permitted or required by the laws of such other state or country.

(G) *Filing procedure:* The commissioner of insurance may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to this act as are necessary, proper or advisable to the administration of this act. This provision shall not abridge any other authority granted the commissioner of insurance by law.

(H) (1) No policy issued by an insurer to which this section applies shall contain a provision which excludes, limits or otherwise restricts coverage because medicaid benefits as permitted by title XIX of the social security act of 1965 are or may be available for the same accident or illness.

(2) Violation of this subsection shall be subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

Sec. 7. K.S.A. 2014 Supp. 40-3401 is hereby amended to read as follows: 40-3401. As used in this act the following terms shall have the meanings respectively ascribed to them herein.

(a) "Applicant" means any health care provider.

(b) "Basic coverage" means a policy of professional liability insurance required to be maintained by each health care provider pursuant to the provisions of ~~subsection (a) or (b) of~~ K.S.A. 40-3402(a) or (b), and amendments thereto.

(c) "Commissioner" means the commissioner of insurance.

(d) "Fiscal year" means the year commencing on the effective date of this act and each year, commencing on the first day of July thereafter.

(e) "Fund" means the health care stabilization fund established pursuant to ~~subsection~~

~~(a) of~~ K.S.A. 40-3403(a), and amendments thereto.

(f) "Health care provider" means a person licensed to practice any branch of the healing arts by the state board of healing arts, a person who holds a temporary permit to practice any branch of the healing arts issued by the state board of healing arts, a person engaged in a postgraduate training program approved by the state board of healing arts, a medical care facility licensed by the state of Kansas, a podiatrist licensed by the state board of healing arts, a health maintenance organization issued a certificate of authority by the commissioner ~~of insurance~~, an optometrist licensed by the board of examiners in optometry, a pharmacist licensed by the state board of pharmacy, a licensed professional nurse who is authorized to practice as a registered nurse anesthetist, a licensed professional nurse who has been granted a temporary authorization to practice nurse anesthesia under K.S.A. 65-1153, and amendments thereto, a professional corporation organized pursuant to the professional corporation law of Kansas by persons who are authorized by such law to form such a corporation and who are health care providers as defined by this subsection, a Kansas limited liability company organized for the purpose of rendering professional services by its members who are health care providers as defined by this subsection and who are legally authorized to render the professional services for which the limited liability company is organized, a partnership of persons who are health care providers under this subsection, a Kansas not-for-profit corporation organized for the purpose of rendering professional services by persons who are health care providers as defined by this subsection, a nonprofit corporation organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine, a dentist certified by the state board of healing arts to administer anesthetics under

K.S.A. 65-2899, and amendments thereto, a psychiatric hospital licensed prior to January 1, 1988, and continuously thereafter under K.S.A. 75-3307b, and amendments thereto, or a mental health center or mental health clinic licensed by the state of Kansas. On and after January 1, 2015, "health care provider" also means a physician assistant licensed by the state board of healing arts, a licensed advanced practice registered nurse who is authorized by the state board of nursing to practice as an advanced practice registered nurse in the classification of a nurse-midwife, a licensed advanced practice registered nurse who has been granted a temporary authorization by the state board of nursing to practice as an advanced practice registered nurse in the classification of a nurse-midwife, a nursing facility licensed by the state of Kansas, an assisted living facility licensed by the state of Kansas or a residential health care facility licensed by the state of Kansas. "Health care provider" does not include: (1) Any state institution for people with intellectual disability; (2) any state psychiatric hospital; (3) any person holding an exempt license issued by the state board of healing arts or the state board of nursing; (4) any person holding a visiting clinical professor license from the state board of healing arts; (5) any person holding an inactive license issued by the state board of healing arts; (6) any person holding a federally active license issued by the state board of healing arts; (7) an advanced practice registered nurse who is authorized by the state board of nursing to practice as an advanced practice registered nurse in the classification of nurse-midwife or nurse anesthetist and who practices solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who~~, in addition to such employment or assignment,~~ provides professional services as a charitable health care provider as defined under K.S.A. 75-6102, and amendments thereto; or (8) a physician assistant licensed by the state board

of healing arts who practices solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who~~, in addition to such employment or assignment,~~ provides professional services as a charitable health care provider as defined under K.S.A. 75-6102, and amendments thereto.

(g) "Inactive health care provider" means a person or other entity who purchased basic coverage or qualified as a self-insurer on or subsequent to the effective date of this act but who, at the time a claim is made for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider, does not have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.

(h) "Insurer" means any corporation, association, reciprocal exchange, inter-insurer and any other legal entity authorized to write bodily injury or property damage liability insurance in this state, including workers compensation and automobile liability insurance, pursuant to the provisions of the acts contained in article 9, 11, 12 or 16 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

(i) "Plan" means the operating and administrative rules and procedures developed by insurers and rating organizations or the commissioner to make professional liability insurance available to health care providers.

(j) "Professional liability insurance" means insurance providing coverage for legal liability arising out of the performance of professional services rendered or which should have been rendered by a health care provider.

(k) "Rating organization" means a corporation, an unincorporated association, a

partnership or an individual licensed pursuant to K.S.A. 40-956, and amendments thereto, to make rates for professional liability insurance.

(l) "Self-insurer" means a health care provider who qualifies as a self-insurer pursuant to K.S.A. 40-3414, and amendments thereto.

(m) "Medical care facility" means the same when used in the health care provider insurance availability act as the meaning ascribed to that term in K.S.A. 65-425, and amendments thereto, except that as used in the health care provider insurance availability act such term, as it relates to insurance coverage under the health care provider insurance availability act, also includes any director, trustee, officer or administrator of a medical care facility.

(n) "Mental health center" means a mental health center licensed by the state of Kansas under K.S.A. 75-3307b, and amendments thereto, except that as used in the health care provider insurance availability act such term, as it relates to insurance coverage under the health care provider insurance availability act, also includes any director, trustee, officer or administrator of a mental health center.

(o) "Mental health clinic" means a mental health clinic licensed by the state of Kansas under K.S.A. 75-3307b, and amendments thereto, except that as used in the health care provider insurance availability act such term, as it relates to insurance coverage under the health care provider insurance availability act, also includes any director, trustee, officer or administrator of a mental health clinic.

(p) "State institution for people with intellectual disability" means Winfield state hospital and training center, Parsons state hospital and training center and the Kansas neurological institute.

(q) "State psychiatric hospital" means Larned state hospital, Osawatomie state hospital and Rainbow mental health facility.

(r) "Person engaged in residency training" means:

(1) A person engaged in a postgraduate training program approved by the state board of healing arts who is employed by and is studying at the university of Kansas medical center only when such person is engaged in medical activities which do not include extracurricular, extra-institutional medical service for which such person receives extra compensation and which have not been approved by the dean of the school of medicine and the executive vice-chancellor of the university of Kansas medical center. Persons engaged in residency training shall be considered resident health care providers for purposes of K.S.A. 40-3401 et seq., and amendments thereto; and

(2) a person engaged in a postgraduate training program approved by the state board of healing arts who is employed by a nonprofit corporation organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine or who is employed by an affiliate of the university of Kansas school of medicine as defined in K.S.A. 76-367, and amendments thereto, only when such person is engaged in medical activities which do not include extracurricular, extra-institutional medical service for which such person receives extra compensation and which have not been approved by the chief operating officer of the nonprofit corporation or the chief operating officer of the affiliate and the executive vice-chancellor of the university of Kansas medical center.

(s) "Full-time physician faculty employed by the university of Kansas medical center"

means a person licensed to practice medicine and surgery who holds a full-time appointment at the university of Kansas medical center when such person is providing health care.

(t) "Sexual act" or "sexual activity" means that sexual conduct which constitutes a criminal or tortious act under the laws of the state of Kansas.

(u) "Board" means the board of governors created by K.S.A. 40-3403, and amendments thereto.

(v) "Board of directors" means the governing board created by K.S.A. 40-3413, and amendments thereto.

(w) "Locum tenens contract" means a temporary agreement not exceeding 182 days per calendar year that employs a health care provider to actively render professional services in this state.

(x) "Professional services" means patient care or other services authorized under the act governing licensure of a health care provider.

(y) "Health care facility" means a nursing facility, an assisted living facility or a residential health care facility as all such terms are defined in K.S.A. 39-923, and amendments thereto.

Sec. 8. K.S.A. 2014 Supp. 40-3414 is hereby amended to read as follows: 40-3414. (a) Any health care provider~~,~~ or any health care system organized and existing under the laws of this state which owns and operates ~~two or~~ more than one medical care ~~facilities~~ facility or more than one health care facility, as defined in K.S.A. 40-3401, and amendments thereto, licensed by the state of Kansas, whose aggregate annual insurance premium is or would be $100,000 or more for basic coverage calculated in accordance with rating procedures approved by the commissioner

pursuant to K.S.A. 40-3413, and amendments thereto, may qualify as a self-insurer by obtaining a certificate of self-insurance from the board of governors. Upon application of any such health care provider or health care system, on a form prescribed by the board of governors, the board of governors may issue a certificate of self-insurance if the board of governors is satisfied that the applicant is possessed and will continue to be possessed of ability to pay any judgment for which liability exists equal to the amount of basic coverage required of a health care provider obtained against such applicant arising from the applicant's rendering of professional services as a health care provider. In making such determination the board of governors shall consider: (1) The financial condition of the applicant;; (2) the procedures adopted and followed by the applicant to process and handle claims and potential claims;; (3) the amount and liquidity of assets reserved for the settlement of claims or potential claims; and (4) any other relevant factors. The certificate of self-insurance may contain reasonable conditions prescribed by the board of governors. Upon notice and a hearing in accordance with the provisions of the Kansas administrative procedure act, the board of governors may cancel a certificate of self-insurance upon reasonable grounds therefor. Failure to pay any judgment for which the self-insurer is liable arising from the self-insurer's rendering of professional services as a health care provider, the failure to comply with any provision of this act or the failure to comply with any conditions contained in the certificate of self-insurance shall be reasonable grounds for the cancellation of such certificate of self-insurance. The provisions of this subsection shall not apply to the Kansas soldiers' home, the Kansas veterans' home or to any person who is a self-insurer pursuant to subsection (d) or (e).

(b) Any such health care provider or health care system that holds a certificate of self-insurance shall pay the applicable surcharge set forth in ~~subsection (c) of~~ K.S.A. 40-3402(c), and

amendments thereto.

(c) The Kansas soldiers' home and the Kansas veterans' home shall be self-insurers and shall pay the applicable surcharge set forth in ~~subsection (c) of~~ K.S.A. 40-3402(c), and amendments thereto.

(d) Persons engaged in residency training as provided in ~~subsections (r)(1) and (2) of~~ K.S.A. 40-3401(r)(1) and (2), and amendments thereto, shall be self-insured by the state of Kansas for occurrences arising during such training, and such person shall be deemed a self-insurer for the purposes of the health care provider insurance availability act. Such self-insurance shall be applicable to a person engaged in residency training only when such person is engaged in medical activities which do not include extracurricular, extra-institutional medical service for which such person receives extra compensation and which have not been approved as provided in ~~subsections (r)(1) and (2) of~~ K.S.A. 40-3401(r)(1) and (2), and amendments thereto.

(e) (1) A person engaged in a postgraduate training program approved by the state board of healing arts at a medical care facility or mental health center in this state may be self-insured by such medical care facility or mental health center in accordance with this subsection (e) and in accordance with such terms and conditions of eligibility therefor as may be specified by the medical care facility or mental health center and approved by the board of governors. A person self-insured under this subsection (e) by a medical care facility or mental health center shall be deemed a self-insurer for purposes of the health care provider insurance availability act. Upon application by a medical care facility or mental health center, on a form prescribed by the board of governors, the board of governors may authorize such medical care facility or mental health center to self-insure persons engaged in postgraduate training programs approved by the

state board of healing arts at such medical care facility or mental health center if the board of governors is satisfied that the medical care facility or mental health center is possessed and will continue to be possessed of ability to pay any judgment for which liability exists equal to the amount of basic coverage required of a health care provider obtained against a person engaged in such a postgraduate training program and arising from such person's rendering of or failure to render professional services as a health care provider.

(2) In making such determination the board of governors shall consider: (A) The financial condition of the medical care facility or mental health center; (B) the procedures adopted by the medical care facility or mental health center to process and handle claims and potential claims; (C) the amount and liquidity of assets reserved for the settlement of claims or potential claims by the medical care facility or mental health center; and (D) any other factors the board of governors deems relevant. The board of governors may specify such conditions for the approval of an application as the board of governors deems necessary. Upon approval of an application, the board of governors shall issue a certificate of self-insurance to each person engaged in such postgraduate training program at the medical care facility or mental health center who is self-insured by such medical care facility or mental health center.

(3) Upon notice and a hearing in accordance with the provisions of the Kansas administrative procedure act, the board of governors may cancel, upon reasonable grounds therefor, a certificate of self-insurance issued pursuant to this subsection (e) or the authority of a medical care facility or mental health center to self-insure persons engaged in such postgraduate training programs at the medical care facility or mental health center. Failure of a person engaged in such postgraduate training program to comply with the terms and conditions of eligibility to

be self-insured by the medical care facility or mental health center, the failure of a medical care facility or mental health center to pay any judgment for which such medical care facility or mental health center is liable as self-insurer of such person, the failure to comply with any provisions of the health care provider insurance availability act or the failure to comply with any conditions for approval of the application or any conditions contained in the certificate of self-insurance shall be reasonable grounds for cancellation of such certificate of self-insurance or the authority of a medical care facility or mental health center to self-insure such persons.

(4) A medical care facility or mental health center authorized to self-insure persons engaged in such postgraduate training programs shall pay the applicable surcharge set forth in ~~subsection (e) of~~ K.S.A. 40-3402(c), and amendments thereto, on behalf of such persons.

(5) As used in this subsection (e), "medical care facility" does not include the university of Kansas medical center or those community hospitals or medical care facilities described in ~~subsection (r)(2) of~~ K.S.A. 40-3401(r)(2), and amendments thereto.

(f) For the purposes of subsection (a), "health care provider" may include each health care provider in any group of health care providers who practice as a group to provide physician services only for a health maintenance organization, any professional corporations, partnerships or not-for-profit corporations formed by such group and the health maintenance organization itself. The premiums for each such provider, health maintenance organization and group corporation or partnership may be aggregated for the purpose of being eligible for and subject to the statutory requirements for self-insurance as set forth in this section.

(g) The provisions of subsections (a) and (f), relating to health care systems, shall not affect the responsibility of individual health care providers as defined in ~~subsection (f) of~~ K.S.A.

40-3401(f), and amendments thereto, or organizations whose premiums are aggregated for purposes of being eligible for self-insurance from individually meeting the requirements imposed by K.S.A. 40-3402, and amendments thereto, with respect to the ability to respond to injury or damages to the extent specified therein and K.S.A. 40-3404, and amendments thereto, with respect to the payment of the health care stabilization fund surcharge.

(h) Each private practice corporation or foundation and their full-time physician faculty employed by the university of Kansas medical center and each nonprofit corporation organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine shall be deemed a self-insurer for the purposes of the health care provider insurance availability act. The private practice corporation or foundation of which the full-time physician faculty is a member and each nonprofit corporation organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine shall pay the applicable surcharge set forth in ~~subsection (a) of~~ K.S.A. 40-3404(a), and amendments thereto, on behalf of the private practice corporation or foundation and their full-time physician faculty employed by the university of Kansas medical center or on behalf of a nonprofit corporation organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine.

(i) (1) Subject to the provisions of paragraph (4), for the purposes of the health care provider insurance availability act, each nonprofit corporation organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated

with the university of Kansas school of medicine shall be deemed to have been a health care provider as defined in K.S.A. 40-3401, and amendments thereto, from and after July 1, 1997.

(2) Subject to the provisions of paragraph (4), for the purposes of the health care provider insurance availability act, each nonprofit corporation organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine shall be deemed to have been a self-insurer within the meaning of subsection (h) ~~of this section~~, and amendments thereto, from and after July 1, 1997.

(3) Subject to the provisions of paragraph (4), for the purposes of the health care provider insurance availability act, the election of fund coverage limits for each nonprofit corporation organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine shall be deemed to have been effective at the highest option, as provided in ~~subsection (l) of~~ K.S.A. 40-3403(l), and amendments thereto, from and after July 1, 1997.

(4) No nonprofit corporation organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine shall be required to pay to the fund any annual premium surcharge for any period prior to the effective date of this act. Any annual premium surcharge for the period commencing on the effective date of this act and ending on June 30, 2001, shall be prorated.";

Also on page 4, in line 4, after "40-19a11" by inserting ", 40-2203"; also in line 4, after "40-4201" by inserting "and K.S.A. 2014 Supp. 40-2,118, 40-22a13, 40-3401 and 40-3414";

And by renumbering sections accordingly;

On page 1, in the title, in lien 2, after "dental" by inserting "service"; in line 3, after the semicolon by inserting " required provisions; certain definitions; the health care provider insurance availability act; definitions; self insurance, health care systems;"; also in line 3, after "40-19a11" by inserting ", 40-2203"; also in line 3 after the last "and" by inserting "K.S.A. 2014 Supp. 40-2,118, 40-22a13, 40-3401 and 40-3414 and";

And your committee on conference recommends the adoption of this report.

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Conferees on part of Senate

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Conferees on part of House